VIEWPOINT

Re-Treating Pandemics

The pandemic treaty negotiations may fail – if so, what can we constructively build upon that so far has been achieved and even improve upon

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Recommended citation:
Pannenborg O, Seifman R. Re-Treating Pandemics.
JGPOH 2024. Posted: DATE: 17/04/2024, DOI: 10.61034/JGPOH-2024-10

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Abstract

The current final stage negotiations for a new pandemic treaty are moving towards a dead-end situation. Concerns of national sovereignty are dominating today's pandemic negotiations. In this situation there are two lower-level approaches and a third option:

I. build on and expand the *technical* pandemic systems,
II. regionalize pandemic alert and control systems
III. establish a tri-partite pandemic agency

In conclusion we propose a regionalization of the pandemic treaty structure.

***Keywords**: Pandemic Treaty, regionalization, financing*

Conflict of interests: None declared

It is not that long ago that Richard Falk, in his Studies of Future Worlds (1), build on the concept of global responsibilities and solutions for global problems. For a while the world community saw the logic of this approach and deepened both its policy and practice in this respect. Several collective and joint objectives were agreed upon by countries and governments that superseded single and individual country interests and accepted treaty obligations that were global in nature and, under United Nations and UN Security Council authority, moved towards world governmental responsibilities, as outlined by Falk. Examples include the Montreal Protocol, the Paris Climate Treaty and the early pandemic International Health Regulations (IHRs). Similar to EU supra-nationality within its community of nations, the principle of subsidiarity applied – where a responsibility or authority can better be discharged at national level, international involvement or engagement stays away.

This policy was further expanded by the UN SC resolution R2P (2005) (2) *Responsibility-to-Protect* in the context of the international community's duty to protect civilians in situations where sovereignty arguments would interfere. As Koffi Annan as UN Secertary-General observed at the time "if humanitarian intervention is indeed an unacceptable assault on sovereignty, how should we respond to a Rwanda, to a Srebrenica?".

Pandemics are not in the realm of genocide, war crimes, ethnic cleansing and crimes against humanity. Preventing and effectively responding to the risk of pandemics, which have cost many more lives worldwide than many a crime against humanity or even genocides, however, equally cannot be achieved unless undertaken by the international community as a whole. The last COVID-19 pandemic is a sad illustration of this fact.

The current final stage negotiations for a new pandemic treaty, the results of which are to be submitted to the World Health Assembly (WHA) next month i.e. in May 2024, are moving in the opposite direction of Falk's concepts and the R2P global policies. In line with the world community's retreat from the R2P liberal interventional policies of a decade ago, concerns of national sovereignty are dominating today's pandemic negotiations (3).

At this stage it is unlikely that the parameters of these negotiations will change towards a more collective approach and the result likely will entail a draft pandemic treaty that will embrace almost the opposite, that is, explicitly allows sovereignty arguments to limit global and collective interventions to prepare, prevent and respond to the risks of pandemics effectively.

Recognizing that, if the proposed Pandemic Treaty text indeed gets adopted by the 77th World Health Assembly (WHA), it will remain essentially toothless in terms of joint and collective global actions, however, we suggest that even then not all is lost. We propose that in that case there are two lower-level approaches that may still yield positive actions and pandemic results, that are worth pursuing. They would well fit within the context of the current draft of the pandemic treaty text.

We also suggest a third option, which in time may become viable, depending on how the global community and its (dis)ordering dynamics and considerations of national sovereignty will evolve over the next decades.

The three approaches are as follows:

I. build on and expand the ***technical* pandemic systems**, e.g. GISAID, the PABS (4) set-up proposed under the current negotiations, CEPI (5), etc.

II. ***regionalize* pandemic** alert and control systems

III. go beyond and ***establish a tri-partite pandemic agency*** a la the International Labor Organization (ILO), with regional and global funding.

I. Professional and technical institutions active in pandemic research, epidemiology or clinical response are increasingly subjected to (geo)political influences, limiting their ability to effectively cooperate with immediate colleagues elsewhere in the world. An exception in this respect, even throughout the COVID-19 pandemic, is the GISAID partnership (Global Initiative on Sharing All Influenza Data) (6). Its effectiveness in early detection and subsequent prevention and control of influenza (avian and other) pathogens that are pandemic-prone remains impressive.

The current pandemic treaty negotiations draft text includes the proposal for a WHO Pathogen Access and Benefit-Sharing System (WHO PABS), in close conjunction with its current institutes and related *national* agencies in this field (e.g. the WHO Hub for Pandemic and Epidemic Intelligence in Berlin, its Epidemic Intelligence unit from Open Sources, and many infectious disease organizations that are *national* in nature but *internationally* active).

All of the Treaty-proposed mechanisms will be subject to the same geopolitical dynamics that prevented the IHRs and WHO and the other public multilateral organizations to act in the global interest during the last pandemic (the absence of the UN Security Council during the pandemic is a great illustration of supranational retreat).

In case the new pandemic treaty fails or gets adopted essentially without teeth and results in a cosmetic makeover of the more recent equally non-effective pandemic prevention arrangements, all is not necessarily lost. Strengthening or setting up new arrangements and systems and collaborations among technical and professional pandemic entities that explicitly stay away from and avoid engagement with political constituencies has significant promise, lots of -global and regional- space to develop in, would not be short of funding in today's international financial structure, and could largely remain beyond the world's sovereignty inclinations of today.

II. Regional pandemic collaboration structures could be alternatives to a global, one-size-fits-all approach. We know there are instances in which centralization responses or solutions to global challenges have sometimes worked (e.g. the 2015 Paris Climate Accord Treaty; the 1987 Montreal Protocol) and even the 1969 first set of IHR pandemic regulations covering six diseases are examples (7).

As observed above, the centralization at global level of trying to find solutions to worldwide problems, however, runs into the polarization of the participating powers. At *regional level* these dynamics generally play out very differently and often more constructively.

One can envision regional pandemic collaboration structures, conceivably clustered around various existing Centers for Disease Control and Prevention (CDCs), and supported by the regional organization concerned such as the Association of Southeast Asian Nations (ASEAN) for East Asia, the African Union (AU) for Africa, the Gulf Cooperation Council (GCC) for the Middle East, or the Organization of American States (OAS). These could be financed by regional financial development institutions, with the assistance of other multilateral financing entities. WHO Regional Offices, especially those with a history of being able to act on their own separate from WHO Headquarters/Geneva (these could become stronger pandemic hubs in their own right).

If then linked to the above-mentioned technical organizations in their region, it could well make for six or seven regional pandemic power houses that would be largely shielded from the global geopolitical positions of the great powers of the day.

Taking Africa and East Asia as examples, the former would likely function viably with a pandemic combination of the Africa CDC -with its three sub-regional institutes-, the African Union Directorate of Health and Humanitarian Affairs (AU HHS), the WHO Regional Office for Africa (AFRO), with funding support from various sources including the African Development Bank (AfDB), Islamic Development Bank (ISDB), the World Bank Group, as well as other Asian, Middle-East and Western development financing agencies. Further, regional collaboration entities such as SADC, EAC and ECOWAS (8), aided by continental leaders from East, West, Central and Southern Africa, supported by public and private disease-related research, and academic organizations, could create a formidable and effective combination (9).

East Asia could well see a similar set-up, with ASEAN (10), the Asian Development Bank (ADB) in Manila, CCDC (11) and WPRO (WHO Western Pacific Regional Office) and leading infectious disease organizations in Thailand, Indonesia, Vietnam, Japan, Korea (the International Vaccine Institute -IVI- in Seoul) and the Philippines. This would represent a formidable combination of pandemic analytical, preventive and response systems, including production and regional distribution of pandemic supplies. The recent closer collaboration between the Asian Infrastructure Investment Bank (AIIB), the ADB and the World Bank (combining their capitalization powers) might also act as a pandemic catalyzer.

It is essential that private sector pandemic leadership, whether pharmaceutical, medical technology, clinical, research & development, academia or financial, have a role in every pandemic system consultation within and among the regions. The model of the World Economic Forum and its regional dimensions may well serve as a viable illustration.

III. A new tripartite pandemic global agency could address many of the problems identified. It may seem presumptuous to suggest at the very moment when a pandemic treaty and its mechanisms are in final discussion. However, taking into account the possibility and risk that either the upcoming last session of the negotiations will fail to agree on a text that can be submitted

to the World Health Assembly, or the product will be aspirational only, have limited compliance terms, or remains powerless and ignored, it makes sense to consider other options for the long term.

We have been here before in the 1990s. When the HIV/AIDS epidemic materialized and new tools for malaria and tuberculosis (TB) became evident, the global constituencies concerned with them originally proposed to enhance the programs for these three diseases across the various UN agencies (WHO, UNICEF, UNDP), Non-Governmental Organizations (NGOs) and financial institutions, such as the World Bank and the regional development banks.

As known now, in the end insufficient confidence emerged among the leading international powers at the time that these priorities would indeed remain priorities in these agencies -rather than being 'mainstreamed'-, that three separate new agencies were created: UNAIDS, the Global Fund for AIDS, TB and Malaria, and the Global Vaccine Alliance (GAVI).

The past record where infectious diseases that become pandemics were given inadequate focus and resources, suggest that an alternative could be a more inclusive global pandemic agency. The model that comes to mind is the one on which the International Labor Organization (ILO) operates. While formally also a UN agency, the ILO long preceded the UN and is basically a tripartite agency at which governments, workers and employers are equally represented and shape the agenda. A pandemic agency could be designed with structural equivalence for key constituting parties. For example, there could be a category of representation for governments, for the private sector and for civil society. Within those three overarching categories, there would be space for private and public research institutes, industry, insurance, and financial organizations, the media, the clinical world, patient voices and communities. This could be a better way to engage core constituencies in pandemic prevention, preparedness and response. It also would integrate human, animal, plant and environmental health, One Health, as an important element of its mandate.

The current draft treaty text proposes a Conference of the Parties (Art. 21) which could function perhaps as outlined above. However, the devil is in the details, as management would be entrusted to its Secretariat, which is housed at WHO itself (Art.24).

The model pursued here is that of the Tropical Disease Research and Training Program (TDR), which is a joint program for research and training for infectious diseases of poverty, overseen by WHO, UNDP, UNICEF and the World Bank and dozens of bilateral and other funders. TDR's Secretariat equally is housed and managed by and in WHO. As such, TDR has been constrained in many of its ambitions and mandate by WHO's 'subculture' and its limited public sector orientation and exclusion of several private sector technical and investment interests.

A freestanding and new global pandemic international agency -not necessarily as part of the UN system-, possibly including aspects of the regionalization outlined above, may well serve the global community better and more effectively than the proposed set-up in the draft pandemic treaty text under consideration (12).

To conclude, for the moment the global community is drifting away from Falk's Future Worlds. The current draft Pandemic Treaty text seems the best we can do and prospects to agree upon a

strong and enforceable agreement to better manage a future pandemic are frankly, dim. If such is the case, there is need now to begin to think, "what else" - going beyond what is now and has been on the table or fallback positions. That would include the technocratic approach outlined above, the regionalization we envisage, and the situation where the world community's mood and its geopolitical power structure were to evolve again towards joint collective action and a separate global pandemic institution would be among its best options.

Simply put, that *what else* is what we hope to highlight with this viewpoint.

References and notes

1. Richard A. Falk, *A Study of Future Worlds*, Institute for World Order, New York, 1975
2. UN 2005 A/RES/60/1 and 2008 S/2007/721
3. See the observations by the WHO Director-General: "*No country will cede any sovereignty to WHO",* see : https://news.un.org/en/story/2023/03/1134967
4. A WHO Pathogen Access and Benefit-Sharing System (PABS System) that aims to ensure rapid, systematic and timely access to biological materials of pathogens with pandemic potential and the genetic sequence data (GSD) for such pathogens.
5. CEPI, the Coalition for Epidemic Preparedness Innovations, is a technical foundation that finances independent research projects to develop vaccines against emerging infectious diseases. It has been among the most effective professional organizations to further prevention and preparedness against future pandemics. See : https://cepi.net/
6. The GISAID Data Science Initiative promotes the rapid sharing of data from priority pathogens. This includes genetic sequencing and related clinical and epidemiological data associated with human viruses, and geographical as well as species-specific data associated with avian and other animal viruses. GISAID does so by overcoming hurdles and restrictions, that discourage or prevented sharing of virological data. https://gisaid.org/about-us/mission/
7. WHO, International Health Regulations 1971, Ch. I, Art. 1 (d), p. 9, j° WHO Charter Art 21 j° Art. 22
8. SADC: the Southern African Development Community, a regional organization that includes all Southern African countries and acts as a powerful regional player; EAC: the East-African Community, similarly a regional economic and political organization (Kenya, Uganda, Tanzania, Rwanda et al.) that acts as the prime powerhouse for East Africa; and ECOWAS: the Economic Community of West African States, a kind of EU set-up for West Africa, albeit at a weaker level and currently with major political challenges.
9. African economic leaders such as Nigeria, South Africa, the EAC (Kenya, Uganda, Tanzania, Rwanda), Senegal, Ivory Coast, Ghana and Ethiopia would likely work well pandemically, also when supported by the various public and private disease and research institutes and companies around the continent (e.g. Afrigen Biologicals, CIDRI-Africa, KEMRI, ICIPE, SACIDS, DELTAS-Africa, ALERRT, etc.).

10. ASEAN: the Association of SouthEast Asian Nations, the most important East Asian economic and political bloc, with Singapore playing a major coordinating role
11. CCDC: China Center for Disease Control and Prevention – created in the 1980s next to the US CDC, the European CDC and the African CDC
12. A useful overview of options under different scenarios is provided in Table 2 in Lawrence Gostin and Rebecca Katz's excellent publication on *The International Health Regulations: The Governing Framework for Global Health Security*, The Milbank Quarterly, 2016, June: 94 (2); 264-313

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